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Does Performing a Spiritual Assessment on a Patient Enhance Patient Outcomes: An Integrative

Literature Review

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Abstract

Background: One aspect that is often overlooked when providing holistic care to patients is spiritual care. Even though a high percentage of people identify as spiritual, there has been limited research conducted to determine its effect on health outcomes.

Purpose: This paper explores through an integrative review the impact of performing a spiritual assessment on patients and if the assessments enhanced patient outcomes.

Methods: The literature review will be guided by a process introduced by Whittemore and Knafl (2005), which includes the following stages: problem identification, literature search, data evaluation, and data analysis. Databases will be searched using keywords spirituality, spiritual assessment, and patient outcome. The Health Belief Model will be used to assess if spiritual beliefs or interventions produce a change in the patient's health outcome.

Results: After analyzing 13 studies, it was found that majority of the studies that examined the impact of a spiritual assessment or spiritual care were largely associated with chronic conditions such as cancer, depression, or a life-threatening condition. Overall, 10 of studies demonstrated some benefit of patient outcome when spirituality was assessed or spiritual care provided.

Conclusion: These studies presented promising information that spiritual care positively impacts a patient's overall health outcome if a patient has a chronic condition. However, until further research is conducted there is little empirical evidence for making concrete assertions about the impact of spirituality and overall patient outcome.

Keywords: spirituality, spiritual assessment, patient outcome

Introduction

Background and Significance

An overarching goal of nursing is to provide patients holistic care that promotes healing within the physical body, cognitive mind, and metaphysical spirit. Zamanzadeh et al. (2015) describes holistic care as “a behavior that recognizes a person as a whole and acknowledges the interdependence among one's biological, social, psychological, and spiritual aspects” (p. 214). By utilizing this comprehensive model, a nurse will attain a better understanding how to assess a patient's progress from day to day.

A daily in-patient nursing assessment usually consists of assessing the patient's airway, breathing, circulation, potential disability, pain scale, hydration status, input and output, potential for risks, and general well being (Nursing Assessment, 2014). Most of these assessments focus on the patient's physical status instead of the non-physical traits such as a patient's state of mind which could be assessed through a routine spiritual assessment. Performing this assessment at least once during the patient's hospital stay could potentially facilitate healing because some patients feel comforted when they feel ‘spiritually connected’ (Wensley, Botti, McKillop, & Merry, 2016). Wensley et al. (2016) described spiritual connectedness as “a connection with a higher power, particularly during times of fear or uncertainty” (p. 5). Therefore, if a nurse performs a spiritual assessment on a patient as a part of the routine assessment and discovers he or she desires further spiritual care, the nurse can connect the patient with the appropriate resources to advocate for and ensure holistic care.

Spiritual assessment. The concept of spirituality within a healthcare context is still in development and can be easily overlooked, limiting nursing application (Daaleman, 2012). However, a patient's spiritual assessment could help the nurse understand that medical decisions could be influenced through moral standards, religious doctrine, or spiritual identity (Padilla-

Walker, Barry, Carroll, Madsen, & Nelson, 2008). A patient defined as having a spiritual identity displays a belief in a higher being or deity, which is embedded in their self-identity (Oman et al., 2009). Therefore, when a patient's spirituality is assessed, it provides the nurse the ability to holistically care for the patient with respect to the patient's beliefs.

Anadarajah and Hight (2001) define a spiritual assessment as “a practical first step in incorporating consideration of a patient's spirituality into medical practice” (p. 81). An informal spiritual assessment can consist of listening carefully to the patient's stories when speaking about spiritual thoughts and encouraging reflection on the patient's beliefs. (Anadarajah & Hight, 2001). The more formal approach to a spiritual assessment is asking specific questions that demonstrate if spiritual factors play a role in the patient's life which could affect how the patient relates to their illness, treatment, or recovery (Anadarajah and Hight, 2001). Through utilizing a spiritual assessment, a nurse can identify if a patient desires for spiritual care to be incorporated into their medical care and communicate the patient's wishes to the health care provider.

There a variety of ways to assess a patient's spirituality, many of which were developed by pastoral counselors and nurses (Anadarajah and Hight, 2001). The HOPE questionnaire is one way to assess a patient's spirituality; it is composed of open-ended questions that could explore a patient's spirituality but does not initially focus on the term “spirituality” (Anadarajah and Hight, 2001). Table 1 demonstrates questions that may be asked in an inpatient setting.

Examples of Questions for the HOPE Approach to Spiritual Assessment	
H: Sources of hope, meaning, comfort, strength, peace, love and connection	<p>We have been discussing your support systems. I was wondering, what is there in your life that gives you internal support?</p> <p>What are your sources of hope, strength, comfort and peace?</p> <p>What do you hold on to during difficult times?</p> <p>What sustains you and keeps you going?</p> <p>For some people, their religious or spiritual beliefs act as a source of comfort and strength in dealing with life's ups and downs; is this true for you?</p>
O: Organized religion	<p>Do you consider yourself part of an organized religion?</p> <p>How important is this to you?</p> <p>What aspects of your religion are helpful and not so helpful to you?</p> <p>Are you part of a religious or spiritual community? Does it help you? How?</p>

P: Personal spirituality/practices	<p>Do you have personal spiritual beliefs that are independent of organized religion? What are they?</p> <p>Do you believe in God? What kind of relationship do you have with God?</p> <p>What aspects of your spirituality or spiritual practices do you find most helpful to you personally? (e.g., prayer, meditation, reading scripture, attending religious services, listening to music, hiking, communing with nature)</p>
E: Effects on medical care and end-of-life issues	<p>Has being sick (or your current situation) affected your ability to do the things that usually help you spiritually? (Or affected your relationship with God?)</p> <p>As a doctor, is there anything that I can do to help you access the resources that usually help you?</p> <p>Are you worried about any conflicts between your beliefs and your medical situation/care/decisions?</p> <p>Would it be helpful for you to speak to a clinical chaplain/community spiritual leader?</p> <p>Are there any specific practices or restrictions I should know about in providing your medical care? (e.g., dietary restrictions, use of blood products)</p>

Table 1. HOPE Questionnaire. Taken from: Anandarajah, G., Hight, E. (2001). Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment. *American Family Physician*, 63(1), 81-88.

Spiritual care. Anandarajah and Hight (2001) define spiritual care as “recognizing and responding to the multifaceted expressions of spirituality we encounter in our patients and their families” (p.84). General spiritual care can be performed by a nurse because the main focus is on compassionately listening to the patient and does not require specialized spiritual training (Anandarajah and Hight, 2001). Further, providing spiritual care for a patient could extend to caring, supporting, and encouraging the patient to participate in the religious rituals he or she receives comfort from. If a patient desires further spiritual care beyond these tasks, then it would be the nurse’s due diligence to connect the patient with the appropriate medical staff and clergy to ensure holistic care is being achieved.

When a patient indicates a desire for specialized spiritual care, the Clinical Pastoral Education (CPE) chaplains are notified (Anandarajah and Hight, 2001). The chaplains are specially trained to understand many different theological beliefs, rituals, and conflicts (Anandarajah and Hight, 2001). The chaplain may pray with patient, read scripture for patient, or aid the patient in a spiritual ritual. Through facilitating this holistic intervention, the patient may be comforted because their values and beliefs are being incorporated into their care.

Problem Statement

Various previous studies have demonstrated that if a patient is spiritual, it can help the patient have hope during the patient's hospital stay and/or long-term health care treatments. While some patients may provide their own spiritual care, other patients may be willing to accept spiritual care from hospital chaplains if prompted by the spiritual assessment. However, there has been minimal research to determine if there is a relationship between performing a spiritual assessment on patients and their overall health outcome. Therefore, because the spiritual assessment is not performed, patient outcomes are correlated with only physical aspects of care given. The purpose of this paper is to reflect on previous research and determine if performing a spiritual assessment leads to accepting spiritual care which would enhance the patient outcome. If the answer is yes, this would strengthen the importance of nurses performing a spiritual assessment routinely on patients to facilitate holistic healing.

Purpose of Integrative Literature Review

The purpose of the integrative literature review is to combine information from previous research to understand if there are benefits to performing a spiritual assessment that would lead to enhanced patient outcome. If enhanced patient outcome is found, then the need for nurses to utilize spiritual assessment as part of the routine nursing assessment in an inpatient setting would be supported.

Research Question

1. Do patients want a nurse to perform a spiritual assessment as a part of their routine care in an inpatient setting?
2. When it is indicated from the spiritual assessment that the patient desires spiritual care, what is the role of the nurse to help facilitate this process?

3. Are there overall health-related outcomes in regards to performing a spiritual assessment?

Conceptual Framework

This literature review will utilize the Health Belief Model to assess if personal beliefs influence the patient's health behavior. The three perceptions that will be utilized from this model are the individual's perception of perceived susceptibility, modifying factors of perceived threat, and the likelihood of action by the individual due to perceived benefits and barriers (Hayden & Paterson, 2013). Through these constructs, a behavioral change may or may not occur based on the individual's perception of the situation.

Perceived susceptibility and/or severity a situation could lead one to choose a behavior that is believed to be associated with health benefits (Hayden & Paterson, 2013). While perceived susceptibility may not lead an individual to change a behavior, the individual's perception of a threat could prompt he or she to alter behavior (Hayden & Paterson, 2013). For example, while it is widely known the use of tanning beds could lead to skin cancer, an individual may still engage in this activity until he or she is diagnosed with skin cancer, now a potentially life-threatening situation instead of just an abstract idea. This leads to the likelihood of action for the perceived benefits an individual is hoping to achieve (Hayden & Paterson, 2013). If an individual ceases tanning, he or she is hoping this health behavior change will have as the goal of stopping the skin cancer progression.

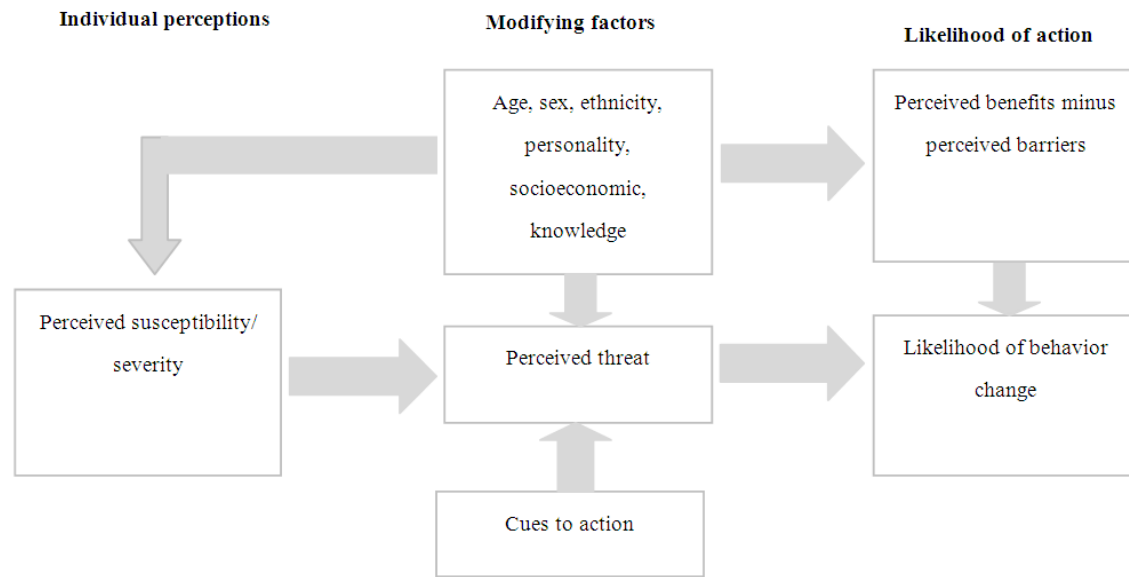


Figure 1. Health Belief Model Framework. Taken from: Chepkemai Ng'etich Mutulei, A. (2013). Factors influencing the uptake of intermittent preventive treatment for malaria in pregnancy: Evidence from Bungoma East District, Kenya. *American Journal of Public Health Research*, 1(5), 110-123.

Methods

Research Design

The design of this study is an integrative literature review aimed at discovering if there is an enhanced patient outcome by performing a spiritual assessment in an inpatient hospital setting. A literature search will be conducted to find recent research pertaining to the effect of performing a spiritual assessment on patients. The literature review will be guided by a process introduced by Whittemore and Knafl (2005), which includes the following stages: problem identification, literature search, data evaluation, and data analysis. The studies will be summarized using a chart matrix and analyzed. Since there has been little research performed on this topic, the literature review will serve as a tool to determine what should be done in future research to address if performing a spiritual assessment enhances patient outcome.

Literature Search Strategies

The integrative review began by using the DePaul University's online library to assess various databases. All of the databases were used to search for research articles and only WorldCat.org and MEDLINE were used. The keywords used to search within the databases were "religious assessment," "spirituality assessment," "spirituality effect on patient outcome," "hope belief model," "spirituality in patients," "patient outcome," "healthcare outcome," "religion and patient outcome," "religiosity," "quality of life," and "nursing assessment." The only two key phrases that produced possible articles to review were "religious assessment" and "healthcare outcome."

Search Limitations and Inclusion/Exclusion Criteria

The search for the integrated literature review was limited to peer-review articles published from 2013 to the 2017. An initial search using the keywords "healthcare outcome" and "religious assessment" generated 573 articles. Only academic journal articles were examined and the database produced 173 articles. Studies that focused on anything besides spiritual care and specific health conditions were excluded, limiting the relevant sources to patient outcome in regards to performing a spiritual assessment, in which 113 appropriate articles were found. After each abstract was considered for this literature review, 9 articles were analyzed. While reading these 9 articles, further research was discovered within these articles that was relevant to this literature review. Therefore, 4 additional articles were chosen to include in this review with dates ranging from 2009 to 2012. A review of the literature was performed and articles were gathered based on selection criteria (Table 2).

Data Analysis

The studies will be analyzed to investigate if performing a spiritual assessment to determine a patient's religiosity and/or spirituality (R/S) enhanced patient outcome. Through

using a chart matrix, the studies will be organized with the following headings: citation, sample, inclusion criteria, objective, analytic procedures, and outcomes. Each study will be compared and contrasted to provide insight on the effect of performing a spiritual assessment as a part of patient care. Through performing this analysis, indications for further research will be noted.

Results

Articles used in this study are grouped according to inclusion criteria (qualitative and/or quantitative) and number of analytical procedures. There were three studies that performed only quantitative analyses and four studies that perform only qualitative analyses. There were six studies that performed both quantitative and qualitative analyses. All of the studies had a similar objective of investigating the relationship between R/S and the patient's medical condition. Three studies involved patients with mental ailments such as depression and psychosis. Three studies investigated the role of R/S in patients who are in hospice or long term care facilities. Two studies involved patients with cancer and two studies involved patients with HIV. One study examined the relationship between R/S and the patient's substance-related disorder. One study focused on the relationship of R/S and cardiovascular disorders. Lastly, one study revolved around patients who were admitted for hospitalization on a medical-surgical floor. Research questions that guided this review were answered to compare overall outcomes and determine unique group features that might provide further incite regarding how R/S affects patient outcome. Summary findings of the papers analyzed in this review are found in Table 3.

Discussion

Coping Impact

Amadi et al. (2016) analyzed the relationship between a patient's depression, coping skills, and treatment outcome. Amadi et al. (2016) found patients with high levels of depression

(BDI-II; $r = 0.2$, $N=224$, $P < 0.05$) who used positive coping skills (MAC Summary Adjustment $r = 0.4$, $N=224$, $P < 0.05$) demonstrated improved treatment outcome over a 12-week period (SDS; $r = 0.2$, $N=224$, $P < 0.05$). On the other hand if the patient used negative coping strategies, then the patient would have an increased psychological distress throughout treatment.

Two studies looked the impact of R/S in HIV patients. Ironson, Kremer, and Lucette (2016) conducted a 17 year longitudinal study that yearly analyzed a patient's CD4 counts, viral load, medication adherence, stress levels and coping strategies. This study found that 5 of the 17 coping strategies predicted reduced mortality and that the patients were two to four times more likely to survive. The coping strategies which demonstrated longer survival were spiritual practices ($HR=0.26$, $p < 0.001$), spiritual reframing ($HR=0.27$, $p = 0.006$), overcoming spiritual guilt ($HR=0.24$, $p < 0.001$), spiritual gratitude ($HR=0.40$, $p = 0.002$), and spiritual empowerment ($HR=0.52$, $p = 0.024$). Dalmida (2009) examined depressive symptoms, a patient's spiritual well-being (SWB), and CD4 count and percentages in African-American women with HIV. This study found that if a patient's SWB scale was high ($r=.24$, $p<.05$) then the patient would have lower depressive scores on the CES-D scale (<16), and a higher CD4 count, representing better immune health.

Another medical condition that was explored was cancer and how R/S plays a role in these patients. The first study analyzed was composed of cancer patients with depression and their perspective on quality of life. (QoL). This study found that patients with anxiety or depression who used positive religious coping expressed a perceived higher QoL than those who did not (Ng, Mohamed, and Zainal, 2016). In this study, positive religious coping consists of when a patient utilizes spiritual beliefs in a way that leads to acceptance, effective coping, and improved overall QoL (Ng, Mohamed, and Zainal, 2016). Another study examined Jordanian

women with breast cancer and found a positive linear relationship between spirituality and QoL ($r = 0.67$, $p = 0.000$; Al-Natour, Al-Moman, and Quandil, 2016). Both of these studies demonstrate promising evidence that the use of religious coping could help cancer patients with depression.

Lastly, research was recently conducted to explore role of spirituality in lifestyle changes within patients who have cardiovascular diseases (CVD). After analyzing 12 studies Janssen-Niemeijer et al (2017) found three themes that emerged from their review. Researchers found that lifestyle changes of patients with CVD occurred when patients felt spiritually connected to a higher power, their community, and experienced peace in the midst of their medical condition.

Overall, the coping impact of R/S has demonstrated to positively impact patients that experience depression, HIV, cancer and cardiovascular disease. In studies regarding depression and cancer, patients perceived their outcome to be more positive when they used R/S as a way to cope throughout their condition. Even if the health status of these patients did not change, such as still battling depression and cancer, the patients believed they were experiencing better QoL than those who did not use R/S as a coping method. Similarly, while the CVD literature review did not examine QoL, the review concluded that patients experienced peace despite their chronic condition. Other the hand, the HIV studies did present quantifiable results regarding patients who incorporated R/S into their healthcare experienced better immune health and a longer survival rate. Through researching more studies that have quantifiable findings regarding R/S and its role in a patient's healthcare, nurses will be able to have justification for assessing a patient's spiritual care status for every patient.

Hospice and Long-Term Care

When examining the literature, a few of the studies demonstrated that spirituality could

play a role in assessing perceived patient outcome for those in long-term care or hospice.

Daaleman (2012) performed a study in which patients were spiritually assessed and separated into groups based on the desire or need for spiritual support during their hospital stay. The 55% of participants who stated they have spiritual needs formed one group (Daaleman, 2012). The patients who received support for their spiritual needs rated their hospital care from facility staff higher than those who did not ($p < 0.001$; Daaleman, 2012). The patients' perceived outcomes were found to be more beneficial in the group which received an intervention than the patients without an intervention.

Since spiritual care has shown to be important for certain patients, it is vital to understand how to accurately perform spiritual care. Yang et al. (2016) initiated a spiritual care program for palliative doctors and nurses to determine if a spiritual assessment leads to performing spiritual care and therefore, improved a patient's QoL and well-being. Three nurses received spiritual care training, while four did not (Yang et al, 2016). There were 70 patients who worked with trained spiritual care nurses, while 74 worked with the four nurses who did not (Yang et al, 2016). Even though the study did not demonstrate a significant improvement of QoL in patients who received the intervention, the study noted that the sample needed to be bigger to draw a definite conclusion ($p = 0.804$; Yang et al, 2016).

Ellis et al. (2012) performed a study which observed the use spiritual care that patients would administer to themselves independently after being admitted into a primary care facility. The results demonstrated that those who considered themselves religious, tended to rely on their religious practices more as the severity of their illness worsened, which aided their perceived QoL ($p < 0.001$). Even though this study focused on those patients who are able to perform their own spiritual care, this review also took one study into consideration which considered what

happens when a patient is unable to make decisions for themselves and a designated surrogate must take over the decision making capacity.

A recent interview study by Geros-Willf, Ivy, Montz, Bohan and Torke (2015) found that that the patient's religious considerations were a vital consideration when a surrogate must make a life or death decision such as code status and withdrawal of care. When 46 surrogates were interviewed about the end of life procedure for their loved one in how decisions were made, three themes emerged (Geros-Willf et al., 2015). The surrogates spoke about using the patient's religion as a guide to make honorable decisions that would bring peace to the patient, enable the family to not feel like they were controlling the patient's life or death, and provide peace to the family as they grieved for their loved one. Even though this study focused on the family while utilizing the patient's R/S preference, this study shows how important it is to be an advocate for the patient when the patient can no longer advocate for themselves.

Health Belief Model

Through analyzing each of these studies in the literature review, a behavioral change either occurred or did not occur based on the patient's perception of their medical situation. The health belief model was used as a guide to determine how interventions impacted a patient's perspective on their health which can affect their overall health outcome. Of the studies that were reviewed, three of them provided spiritual care interventions for patients. Huguelet et al. (2011) studied patients who suffered from psychosis. One group was randomly assigned to have spiritual assessments incorporated into each therapy sessions for three months while the control group did not have this intervention. The results showed significant correlation between the spiritual assessments intervention and how it positively impacted therapy sessions ($r=.42$, $p<.01$). The study found this intervention had a positive impact because 67% of the intervention patients

asked for modified treatment plans to include religious coping into their therapy sessions.

Overall, the patients perceived this action to help them in therapy and led to a modified change in how they approached their treatment.

Another study examined how depression and treatment outcome were related when using appraisal-based comforting conversations. Rafferty, Billing, and Mosack (2014) found that when a patient engaged in appraisal-based comforting conversations about R/S with their healthcare provider, statistically significant findings were more emotional support, $F(1, 104) = 20.21$, $p < .001$, esteem support, $F(1, 104) = 18.56$, $p < .001$, and emotional improvement $F(1, 104) = 41.71$, $p < .001$. Some of these conversations in the study revolved around topics such as silent meditation, community spoken prayer, religious services, or celebrations. Even though the modifying factor, appraisal-based conversations, in the study did not demonstrate quantifiable evidence of a difference in depression levels, the patients still expressed positive emotions and empowerment toward dealing with their depression.

One recent study has replicated past studies regarding how R/S is negatively correlated with drug and alcohol abuse (Gorsuch, 1995; Pardini, Plante, & Sherman, 2000). Parhami et al. (2014) studied the relationship between substance abuse and self-reported R/S in 33 patients at a Jewish residential treatment center. The study found a significant relationship between baseline R/S level of those who remained in treatment for 6 months and those who dropped out before 6 months of treatment. A one-way ANOVA was conducted and a significant difference between these two groups was found at baseline ($F(14, 11) = 7.213$, $p = 0.013$, effect size = 0.481). Even though a specific intervention was not performed, the modifying factor of a religious based institution could have reinforced the patients who identified as religious to remain in treatment.

Limitations of the study

The Huguelet et al. (2011) study demonstrated that having spiritual assessments incorporated into psychosis therapy sessions led to a positive impact in patients, however, the study is limited because the participants were not first assessed to determine the impact spirituality plays a role in their life in the beginning of the three month period. Both of the other studies which examined depression and its relationship with R/S also had limitations. First, Amadi et al. (2016) conducted their study in only two tertiary hospitals. Second, even though the findings of Rafferty, Billing, and Mosack (2014) are positive and provide further incite to the effect of appraisal-based conversations regarding R/S, it did not show a difference in depressions levels when compared to the control group.

The two studies that examined R/S and HIV demonstrated that different R/S coping methods correlates with having a higher viral load and CD4 count. However, both studies were dependent on patient medication adherence. Therefore, if the patients did not adhere to the medication they could possibly experience a lower viral load and CD4 count. Further, the Almida (2016) study was conducted over a 17 year period and did not account for the improvement of HIV medications which could have cause the positive results.

Parhami's study (2014) demonstrated the ability for a specific religious-oriented treatment center to positively impact patients but there was no significant finding the three month retention date. The only significant finding was illustrated for the attendees who remained with the treatment for six months. Daalemann's study (2012) was limited to palliative care; therefore, there is a need for primary care research to be performed. Ellis et al. (2012) did work with primary care patients but did not include patients from urban communities. While Huguelet et al. (2011) discussed that performing spiritual assessment could positively affect patient outcome,

the study only worked with psychosis patients.

The two studies that examined a relationship between cancer patients and R/S both had limitation. Both studies used a cross-sectional design to conduct the studies and Al-Natour et al. (2016) used a convenience sample which could potentially skew the data if the sample was taken from a community that holds R/S in high regard. Geros-Willfond, Ivy, Montz, and Torke (2015) revealed the importance of incorporating the patient's R/S preference even when the patient cannot make their own medical decisions for various reasons. In this study, the surrogate religious beliefs were not accounted for. Overall, all of the studies reviewed revolved around patients with chronic health conditions, needed long term care, or were in hospice. The only exception to this review was one study that followed patients in a primary care setting. Due to this finding, it is important to note that patients with chronic conditions may utilize religious coping methods in different ways than an patients in an inpatient or outpatient setting since there is limited research for this area. Therefore, further research is necessary to determine if performing spiritual assessments in all areas of healthcare affect patient outcome.

Implications for Nursing Practice

These findings emphasize the importance of considering how R/S influence a patient's perspective of their overall health. By developing a health services framework for spiritual care, nurses would be able to offer interdisciplinary support within the clinical nursing context. Implications for nursing practice include considering the patient's perspective, referral services, facilitating religious rituals, and acknowledging religious concerns. This recommendation can be applied to any patient who expresses the desire to have a spiritual care incorporated into their treatment plan. Finally, this literature review supports that nurse educators could design

curriculum to inform future nurses how to effectively perform a spiritual assessment. Then, spiritual care can be implemented and enhance a patient's perceived QoL and well-being.

Conclusion

This review examined 13 studies to determine if there was a collective relationship between performing spiritual care and its impact on a patient QoL. While a specific study was not found if patients want a nurse to perform a spiritual assessment as a part of their routine care, studies have shown that patients may desire R/S to be a part of their care. The studies have shown that the key role of a nurse is to facilitate conversation about this topic to determine if additional resources should be considered. Lastly, this review has provided multiple sources that demonstrate there is a positive relationship between a patient's perceived QoL when R/S is incorporated into their care if desired. Future studies should continue to focus on the specific impact a nurse makes when asking the patient if spiritual care is desired. By doing so, this could lead the patients to experiencing a positive perceived patient outcome regardless of the ailment.

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Databases	WorldCat. org	MEDLINE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Search Terms	religious assessment AND healthcare outcome	religious assessment AND healthcare outcome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initial Search	641	9
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Publication Date 2013- present	567	6
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Academic Journal Articles	169	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major Heading and Term Search	Subject: Major Heading "religion""healthcare"	Subject: Major Heading "religion""healthcare"
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relevant Articles	12	1
Total Articles excluding repeats: 13		

Table 2. Selection criteria of the review of the literature

Table 3. Comparison of online studies in table of papers identified by an integrative literature review

Citation	Sample	Type of Study	Objective	Analytic Procedures	Outcomes
Amadi, K. U., Uwakwe, R., Odinka, P. C., Ndukuba, A. C., Muomah, C. R., & Ohaeri, J. U. (2016)	n=112 Simple random sampling of participants with diabetes and depression	Quantitative	Assess the association between religiosity and coping style with the outcome of depression and diabetes	Religious Orientation Scale (ROS-R) Brief Religious Coping (Brief RCOPE) scale Mental Adjustment to Cancer (MAC) scale Sheehan Disability Scale (SDS) Beck's Depression Inventory-II (BDI-II)	Strength Patients with high levels of depression (BDI-II; $r = 0.2$, $N=224$, $P < 0.05$) who used positive coping skills (MAC Summary Adjustment $r = 0.4$, $N=224$, $P < 0.05$) demonstrated to have improved treatment outcome over a 12 week period (SDS; ($r = 0.2$, $N=224$, $P < 0.05$)) Negative coping strategies correlated with poorer care outcome Weakness Conducted in only 2 tertiary health institutions
Ng, G.C., Mohamed, S., Sulaiman, A.H., Zainal, N.Z. (2016)	n=200 Both in and outpatients with known diagnosis of cancer were included Average duration of cancer=38 months	Quantitative	Investigate the relationship between religiosity and/or religious coping in cancer patients	Duke University Religion Index (DUREL) Brief Religious Coping Scale (RCOPE) Hospital Anxiety and Depression Scale (HADS)	Strength Subjects with anxiety or depression who used more negative religious coping and had lower non-organization religiosity. Subjects with anxiety or depression who used more positive religious coping and had higher non-organization religiosity. Weakness Cross sectional design Small sample size
Yang, GM., Tan, Y.Y., Cheung, Y.B., Lye, W.K., Lim, S.H., Ng, W.R., Puchalski, C., Neo, P.S. (2016)	n=144 Cluster controlled trial: 74 patients in control group and 70 patients received training program intervention.	Quantitative	Determine if a training program for healthcare workers on spirituality and spiritual history results in improved patient quality of life (QoL) and spiritual well-being	Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp) scale Functional Assessment of Cancer Therapy-General (FACT-G) questionnaire	Strength FACT-G scores were higher in intervention group than in the control group demonstrating enhanced improvement in QoL Weakness Small sample The difference between the intervention and control groups in terms of change in spiritual well-being measured by the FACIT-Sp scores did not show evidence of enhanced improvement on the patient's QoL

Huguelet, P., Mohr, S., Betrisey, C., Borrás, L., Gillieron, C., Mancini, A.M., Rieben, I., Perroud, N., M.D., Brandt, P. (2011)	n=78 Psychosis patients were placed in 2 groups: traditional treatment (38) and treatment with a spiritual assessment (40)	Quantitative and Qualitative	Examine acceptance of a spiritual assessment by the patient's psychiatrist and determine suggestions for treatment that arose from the assessment; study took place over a 3 month period.	<p>Quantitative</p> <p>Positive and Negative Syndrome Scale</p> <p>Global Assessment of Functioning scale</p> <p>Social Functioning Questionnaire</p> <p>World Health Organization Quality of Life (WHOQOL)</p> <p>Client Satisfaction Questionnaire (CSQ)</p> <p>Qualitative</p> <p>Mini-International Neuropsychiatric Interview</p> <p>Working Alliance Inventory</p> <p>Hospitalization days, suicide history, treatment adherence</p>	<p>Strength</p> <p>Positive impact of the intervention was shown in patients with psychosis and a large portion of the assessments raised issues judged to be important to clinical care, such as supporting patients' religious coping or helping mobilize them toward clergy or a religious group in the community.</p> <p>67% of the spiritual assessment intervention patients led to specific suggestions for modified treatment after one of the psychiatric supervision sessions.</p> <p>Significant correlation was found between the positive impact of the intervention expressed during supervision and the value that psychiatrists attributed to the intervention ($r=.42$, $p<.01$)</p> <p>Weakness</p> <p>No differences were found across groups in primary and secondary outcome measures.</p>
Rafferty, K.A., Billig, A.K., Mosack, K.E. (2014)	n=138 106 reported having conversation where they linked R/S with their chronic illness and were used for hypothesis testing	Quantitative and Qualitative	Explicate the relationship among R/S and psychological well-being in patients with chronic illness through addressing the role of communication in coping.	<p>Quantitative</p> <p>FACIT-Sp Scale</p> <p>Spirituality/Religiousness Index (SR)</p> <p>Perceived Stress Scale (PSS)</p> <p>Illness Intrusive Rating Scale (IIRS)</p> <p>Depression Anxiety Stress Scale (DASS)</p> <p>Qualitative</p> <p>30-minute survey</p>	<p>Strength</p> <p>Patient engaged in appraisal-based comforting conversations about R/S with their healthcare provider the patient significantly positively perceived to have more emotional support ($F(1, 104) = 20.21$, $p<.001$)) esteem support ($F(1, 104) = 18.56$, $p<.001$)), and emotional improvement, ($F(1, 104) = 41.71$, $p<.001$))</p> <p>Weakness</p> <p>No differences in levels of depression or stress were found between those who reported having a conversation and those who did not</p>
Ironson, G., Kremer, H., & Lucette, A. (2016)	n=177 HIV patients in the mid-stage of disease (150–500 CD4-cells/m3; no prior AIDS defining symptoms)	Quantitative and Qualitative	Examine the use of spirituality/religiousness to cope with HIV survival over 17 years	<p>Quantitative</p> <p>Pargament questionnaire</p> <p>CD4 counts and viral load</p> <p>AIDS Clinical Trial Group adherence measure</p> <p>Qualitative</p> <p>Content analysis of interviews and essays regarding stress and coping with HIV</p>	<p>Strength</p> <p>5 of the 17 coping strategies predicted reduced mortality: Spiritual practices ($HR=0.26$, $p<0.001$), spiritual reframing ($HR=0.27$, $p=0.006$), overcoming spiritual guilt ($HR=0.24$, $p<0.001$), spiritual gratitude ($HR=0.40$, $p=0.002$), and spiritual empowerment ($HR=0.52$, $p=0.024$).</p> <p>Use of overall spiritual coping predicted greater survival and were 2–4 times more likely to survive over a 17 year period</p> <p>Weakness</p> <p>Undetectable VL level due to these improved antiretroviral medications.</p>
Dalmida, S. G.,	n=129	Quantitative and	Examine associations	<p>Quantitative</p> <p>Spiritual Well Being Scale</p>	<p>Strength</p> <p>Higher SWB ($r=.24$, $p<.05$) was significantly</p>

Holstad, M. M., DiIorio, C., Laderman, G. (2009)	African-American women with HIV	Qualitative	of spiritual well-being, with depressive symptoms, and CD4 cell count and percentages in HIV	(SWB) CES-D Depression scale CD4 cell counts and percentages Qualitative Antiretroviral General Adherence Survey for HIV medication adherence	associated with a lower depressive symptom score (<16) Higher SWB was significantly associated with higher CD4 cell counts and percentage, indicating better immune health Weakness Dependent on medication adherence control measure which was provided by patient report and could have been skewed
Parhami, I., Davtian, M., Collard, M., Lopez, J., & Fong, T. W. (2014)	n=33 Subjects were classified into two groups: those who completed six months of treatment and those who dropped out before six months of treatment.	Quantitative and Qualitative	Explore the relationship between R/S, self-reported religious preference, and retention at a Jewish residential treatment center for substance-related disorders.	Quantitative One-way ANOVA was conducted to determine whether there was a difference in DSES scores between the two groups at baseline. Qualitative Daily Experience Scale (DSES) R/S levels were assessed at baseline, 1 month, 3 months, and 6 months	Strength Significant relationship between baseline R/S level and retention at 6 months, reaffirming an association between R/S levels and positive treatment outcomes for substance-related disorders The study found a significant relationship between baseline R/S level of those who remained in treatment for 6 months and those who dropped out before 6 months of treatment was complete. A one-way ANOVA was conducted and a significant difference between these two groups was found at baseline ($F(14,11)=7.213$, $p=0.013$, effect size=0.481) R/S level, rather than religious affiliation, is a possible predictor for better outcome at faith-based residential centers for substance-related disorders Weakness Small sample size Patients with a different religious preference than the faith-based residential setting may experience challenges conforming to the environment developed by center
Al-Natour, A., Al-Moman, S.M., Qandil, A.M. (2016)	n=150 Jordanian women with breast cancer	Quantitative and Qualitative	To investigate the relationship between spirituality and quality of life (QoL) of women diagnosed with breast cancer	Quantitative FACIT-Sp Scale Qualitative Conceptual model used was Watson's Theory of Human Caring	Strength Positive linear relationship was found between spirituality and QoL ($r = 0.67$, $p = 0.000$) Spiritual intervention could contribute to increased functional, social, and physical well-being Weakness Cross sectional design Convenience sample

Daaleman, T.P. (2012)	n=451 Residential care/assisted living patients in nursing homes from four states participating in the Collaborative Studies of Long-Term Care (VS-LTC)	Qualitative	Investigate if patients believe they received quality healthcare care during their ICS-LTC when the patient indicates their spiritual needs/care is provided.	Qualitative thematic content analysis from transcribed interviews.	<p>Strength Care was rated more highly among those who received spiritual care from facility staff than those who did not in the last month of life.</p> <p>The perceived value of care was higher if spiritual care included help with spiritual care practices, relationships, or with coping with illness.</p> <p>A large majority of decedents (87%) received support with their spiritual needs. Residents in RC/AL facilities with fewer than 16 beds were less likely to receive spiritual support (71%) when compared to residents of new-model RC/AL facilities.</p> <p>Weakness Limited to 4 states and 230 residential facilities</p>
Ellis, M.R., Tomlinson, P., Gemmill, C., Harris, W. (2012)	n=326 Inpatients admitted to primary care physicians to 4 midwestern hospitals	Qualitative	Assess how frequently patients identified spiritual concerns during their hospitalization	Qualitative thematic content analysis from transcribed interviews.	<p>Strength Spiritual care was provided to 54% of R/S respondents; 94% found those visits helpful.</p> <p>8% percent of R/S respondents desired spiritual interaction with physician, but only 1 patient received it.</p> <p>64% of these patients' physicians agreed that doctors should address spiritual issues with their patients.</p> <p>Weakness Hospitals were only in the midwest.</p>
Geros-Willfond, K.N., Ivy, S.S., Montz, K., Bohan, S.E., Torke, A.M. (2015)	n=46 Adults age 65 and over that had a surrogate decision maker	Qualitative	Characterize the role of R/S in decision making (concerning procedures, code status and intubation, and hospital discharge) in a skilled nursing	<p>Qualitative thematic content analysis from transcribed semi-structured interviews.</p> <p>Interviews with surrogates were conducted within 1 month of hospital admission and 2 months after the patient passed to assess the R/S role in decision making.</p>	<p>Strength Three major themes related to the role of R/S were identified in decision making: (1) religion as a guide to decision making, (2) control, and (3) faith, death, and dying.</p> <p>Weakness Conducted in only two hospitals in a one metropolitan area.</p> <p>Majority identified religion: Christian</p>
Janssen-Niemeijer, A.J., Visse, M., Leeuwen, R.V., Leget, C., Cusveller, B.S. (2017)	n= 12 Literature review of studies with a qualitative empirical design and mixed methods were analyzed	Qualitative	Investigate and synthesize evidence about the role of spirituality in lifestyle changing in patients with chronic CVD	The Consolidated Criteria for Reporting Qualitative Studies (COREQ)	<p>Strength Three spiritual themes were identified in the lifestyle changes of the patients identified: (1) religion or connectedness to the significant or sacred (2) relationality or connectedness with others (3) meaning and purpose</p> <p>Weakness None of the 12 articles scored positively on all of the COREQ items 3 samples were selective 3 samples were convenient</p>